First Trimester Screening for Preeclampsia and Intrauterine Growth Restriction Using Uterine Artery Doppler and Maternal Serum Placental Growth Factor and Pregnancy Associated Plasma Protein- A

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Abstract

Objective: To assess the accuracy of first-trimester uterine artery Doppler indices combined with maternal serum placental growth factor (PIGF) and pregnancy associated plasma protein- A (PAPP-A) in the prediction of preeclampsia (PE) and intrauterine growth restriction (IUGR) in low risk pregnancy.

Design: Prospective observational study

Patients and methods: A total of 266 low risk singleton pregnant women at12-14 weeks’ gestation were recruited and completed the study. Uterine artery (UtA) color Doppler study was estimated on the two sides, the mean pulsatility index (PI) was calculated and dicrotic diastolic notches were recorded. Estimation of maternal serum PIGF and PAPP-A were performed on the same day. The cut-off of Ut Ar PI was 2.35, the cut-off of PIGF was 12pg/ml and the cut off of PAPP-A was 0.42 MoM. The patients were followed up to detect PE and IUGR. PE developed in 14 cases (5.26 %), 2 cases early-onset 2 cases and late-onset 12 cases and IUGR in 19 cases (7.14 %), early-onset 3 cases and late-onset 16 cases. The sensitivity, specificity, positive and negative value (PPV and NPV) and accuracy were calculated. The higher sensitivity and PPV and accuracy for prediction of PE and IUGR were found when first trimester UtA PI and PIGF were combined. The addition of PAPR-A did not improve the accuracy.

Conclusion: The ideal first trimester markers for prediction of PE and IUGR in low risk pregnant women may be a combination of UtA PI and maternal serum PIGF.

Keywords: Preeclampsia; Intrauterine growth restriction; Uterine artery pulsatility index; Placental growth factor; Pregnancy-associated plasma protein-A

Introduction

Preeclampsia (PE)/eclampsia are the second commonest cause of direct maternal deaths in developed countries. Perinatal mortality in PE and IUGR is 6% and 10% respectively. Modern maternal care relies on prediction of adverse pregnancy outcomes such PE and IUGR early in pregnancy, there by starting early management including a high level of pregnancy monitoring to minimize the risk of expected pregnancy complications [1] both PE and IUGR share the same pathogenesis that is shallow implantation of the placenta that stems from the mother’s immune system responding to the placenta as if it were a foreign invader. This theory suggests that a lack of immunological tolerance in pregnancy results in an auto-immune response to the antigens of the fetus and its placenta [2]. Consequently, PE and IUGR have the same markers for their prediction. As a predictive marker for development of PE and IUGR, uterine artery (UtA) Doppler waveform has been used extensively in the second trimester. Study of first trimester UtA Doppler waveform has been recently used as a better predictive marker for PE and IUGR. This allows early use of aspirin as a protective measure against these adverse pregnancy outcomes [3]. The sensitivity and positive predictive values of the PI of UtA as a predictor marker for PE and IUGR for low risk pregnancy is, around 40%. Combining first trimester UtA PI with variable biochemical markers has been resorted to achieve a detection rate of PE and IUGR approaching 90% [4]. The success rate of this combination is variable. The aim of this study is to assess the success rate of combined UtA PI with PIGF and PAPP-A for predicting the development of PE and IUGR in low risk pregnancy.

Patients and Methods

A total of 300 women were recruited from the outpatient clinic of Obstetrics, Tanta University Hospitals, during the period June 2013 to December 2015.
Inclusion criteria

Primigravida, and singleton pregnancy at 12-14 weeks. Attending regularly the antenatal clinic and delivered at department of Obstetrics, Tanta University Hospitals.

Exclusion criteria

Multiple pregnancies: Women with medical disorders as diabetes mellitus, chronic hypertension, chronic renal, liver, thyroid or autoimmune diseases. Women with congenital or acquired gynaecological lesions. Women pregnant after treatment of infertility, Fetal congenital abnormality, increased nuchal translucency thickness or markers of chromosomal aberration Forty-four women were lost to follow up and 266 women completed the study. The study was approved by the ethics committee of Tanta University Hospital. All women included in the study signed a formal consent. All participants were subjected to detailed history taking and complete medical examination.

A transabdominal ultrasound, including color Doppler study of the uterine arteries, was performed for all pregnant women at 12-14 week’s gestation. All women were followed up to detect the development of PE and IUGR by serial clinical examinations, measurement of blood pressure and detection of proteins in urine in addition to trans abdominal Doppler of UtAs and ultra sound scanning especially fetal biometry, estimated fetal weight and placental morphology. PE was diagnosed when systolic blood pressure was ≥ 140 mm Hg and/ or diastolic blood pressure ≥ 90 mm Hg and proteinuria of ≥ 300 mg in 24 hours or two readings of at least 2+ on dipstick analysis of midstream or catheter specimen in absence of urinary tract infection.

Color Doppler study of the uterine artery

Transabdominal ultrasonography examination with a probe (3.5 MHz) of (Seimen, Omnia, Medison 9900, and Germany) equipped with pulsed color Doppler. Gestational age was confirmed by crown-rump length and fetal viability was assured. The UtA PI was estimated and early diastolic notches were reported if present. Transabdominally, a midsagittal section of the uterus was obtained and the cervical canal was identified. The empty maternal bladder is preferable. The probe was moved laterally until the paracervical vascular plexus was seen.

Color Doppler was turned on and the uterine artery was identified as it turns cranially to make its ascent to the uterine body. Measurements were taken at this point, before the uterine artery branches into the arcuate arteries. Sample gate was set at 2 mm to cover the whole vessel, angle of insonation not more than 30° and the peak systolic velocity should >50 cm to ensure that the arcuate artery were not scanned instead of the UtA. When three similar consecutive waveforms had been obtained the Ut A PI was measured. The mean PI of the two UtAs was used for analysis. On the same day of Doppler study blood sample was obtained from all women allowed to stand in room temperature for 30 minutes then centrifuged at 3000 rpm for 10 minutes and the serum stored at -70°C until analysis.

Assay

All serum samples were assayed for PiGF and PAPP-A. PiGF was measured using commercial enzyme-linked immunosorbent assays (ELISA). PAPP-A was measured using DRG PAPP-A ELISA kit which is a solid phase enzyme linked immunosorbent assay based on the sandwich principle. Both PiGF and PAPP-A were assayed by Quantike ELISA kits from R&D systems Inc. Minneapolis, MN, USA. Cases expected to develop PE or IUGR were provided with special antenatal care to discover these complication as early as possible. Discovered PE and IUGR were managed by routine management for these cases. All delivered in the Department of Obstetrics and Gynecology, Tanta University.

Statistical analysis

Data were statistically described in terms and mean ± standard deviation (±SD). For comparing categorical data, chi Square(X2) test was performed. Receiver operator characteristic (ROC) analysis was used to determine the optimum cut-off value for the studied diagnostic markers. P value less than 0.05 were considered statistically significant. All statistical calculations were done using computer program SPSS (Statistical package for the Social Science: SPSS Inc, Chicago, IL for Microsoft Windows (2006).

Results

The cut-off values of UtA PI, maternal serum PiGF, and PAPP-A in the first-trimester of 266 low risk pregnant women for prediction of PE and IUGR were 2.35, 12 pg/ml and 0.45 MoM respectively. UtA PI was truly positive for PE in 6 cases and falsely negative in 8 cases. Consequently the sensitivity of UtA PI for prediction PE was 45.8%, specificity 84.5%, positive predictive value (PPV) 13.8%, and negative predictive value (NPV) 92.8%. UtA PI was truly positive for IUGR in 9 cases and falsely negative in 10 cases. Consequently the sensitivity of UtA PI for prediction of IUGR was 47.36%, specificity 85.42%, PPV 20% and NPV 95.4%. Maternal serum PiGF was truly positive in 12 cases of IUGR and falsely negative in 7 cases. Consequently its sensitivity for prediction of IUGR was 63.15%, specificity 80.06%, PPV 30.76% and NPV 96.9%.

Combined UtA PI and PiGF for prediction of PE: 13 cases were true positive and 1 case false negative consequently combined UtAPI and PiGF had sensitivity for prediction of PE 92.85%, specificity 99.60%, PPV 92.85% and NPV 99.60%. Combined UtA PI and PiGF for prediction of IUGR:18 cases were truly positive and one case falsely negative. Consequently sensitivity was 94.73%, specificity 91.49%, PPV 46.15% and NPV 99.95% Clinical characteristics, average UtAs PI and maternal serum PiGF of women with PE (14 cases (5.26%), 2 (14.28%) early-onset and 12 (85.71%) late-onset) and women without PE (252 cases) are depicted in Table 1. Gestational at delivery, birth weight were significantly lower in women with PE compared to women without PE UtAs PI was significantly higher in women with PE compared to women without PE. Maternal serum PiGF was
significantly lower in women who developed PE compared to women who did not develop PE.

Clinical Characteristics, average Ut As PI and maternal serum PlGF in women who developed IUGR (19 cases (7.14%), 3(15.78%) early-onset and 16 (84.21%) late-onset) and women who did not develop IUGR (247 cases) are depicted in Table 2. Gestational age at delivery and birth weight were significantly lower in women with IUGR compared to women without IUGR. Ut As PI was significantly higher in women who developed IUGR compared to women who did not develop IUGR. Maternal serum PlGF was significantly lower in women who developed IUGR compared to women who did not develop IUGR.

Tables 3 and 4 predict the accuracy of Ut API cutoff point of >2.35 and PlGF cutoff point<12 pg/ml for prediction of PE and IUGR in low risk pregnancies. Sensitivity, positive predictive value and overall accuracy were significantly higher on combining Ut AsPI with maternal serum PlGF compared to UtA PI or PlGF alone. Specificity and negative predictive value were higher (but not significant) on combining UtA PI with PlGF compared to UtAPI or PlGF alone as they were already high (≥ 85% when each one was used alone for prediction of either PE or IUGR.

Table 1: Clinical characteristics, Doppler results, maternal serum PlGF and PAPP-A in women who developed preeclampsia and women who did not develop preeclampsia. BMI: Body Mass Index; CRL: Crown-Ramp Length; PI: Pulsatility Index; PlGF: Placental Growth Hormone; PAPP-A: Pregnancy Associated Plasma Protein –A.

<table>
<thead>
<tr>
<th></th>
<th>Women with IUGR n=19</th>
<th>Women without IUGR n=247</th>
<th>t/P</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age in years</td>
<td>25 ± 1.6</td>
<td>26 ± 2.12</td>
<td>1.736</td>
<td>0.084</td>
</tr>
<tr>
<td>BMI (Kg/m2)</td>
<td>24.4 ± 2.22</td>
<td>23.8 ± 3.88</td>
<td>0.573</td>
<td>0.567</td>
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<tr>
<td>CRL (mm)</td>
<td>70.0 ± 3.0</td>
<td>68.0 ± 3.0</td>
<td>0.930</td>
<td>0.535</td>
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</tbody>
</table>

Table 2: Clinical characteristics, Doppler results, maternal serum PlGF and PAPP-A in women who developed IUGR and women who did not develop IUGR. BMI: Body Mass Index; CRL: Crown-Ramp Length; PI: Pulsatility Index; PlGF: Placental Growth Hormone; PAPP-A: Pregnancy Associated Plasma Protein –A.

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<th>Women without IUGR n=247</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Age in years</td>
<td>26.3 ± 1.85</td>
<td>26.78 ± 3.78</td>
<td>0.548</td>
<td>0.584</td>
</tr>
<tr>
<td>BMI (Kg/m2)</td>
<td>23.53 ± 2.47</td>
<td>23.8 ± 3.88</td>
<td>1.719</td>
<td>0.087</td>
</tr>
<tr>
<td>CRL (mm)</td>
<td>65.0 ± 6.0</td>
<td>63.8 ± 3.0</td>
<td>1.531</td>
<td>0.127</td>
</tr>
<tr>
<td>Gestational age at delivery (weeks)</td>
<td>34.82 ± 1.24</td>
<td>38.21 ± 3.11</td>
<td>4.887</td>
<td>0.001</td>
</tr>
<tr>
<td>Presence of uterine artery diastolic notch (n %)</td>
<td>11(57.9)</td>
<td>93 (37.65)</td>
<td>3.036</td>
<td>0.081</td>
</tr>
<tr>
<td>Average uterine artery PI</td>
<td>2.58 ± 0.04</td>
<td>2.21 ± 0.22</td>
<td>7.309</td>
<td>0.001</td>
</tr>
<tr>
<td>Serum PlGF (pg/ml)</td>
<td>8.2 ± 0.6</td>
<td>27.6 ± 1.8</td>
<td>1.445</td>
<td>0.001</td>
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<tr>
<td>Serum PAPP-A (MoM)</td>
<td>0.47 ± 0.003</td>
<td>0.64 ± 0.03</td>
<td>1.532</td>
<td>0.001</td>
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<table>
<thead>
<tr>
<th>Cutoff points</th>
<th>Sensitivity %</th>
<th>Specificity %</th>
<th>PPV %</th>
<th>NPV %</th>
<th>Accuracy %</th>
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</thead>
<tbody>
<tr>
<td>UtA PI (&gt;2.35)</td>
<td>42.8</td>
<td>84.52</td>
<td>13.5</td>
<td>97.73</td>
<td>82.33</td>
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<tr>
<td>PlGF (&lt;12 pg/ml)</td>
<td>64.28</td>
<td>91.26</td>
<td>33.33</td>
<td>97.87</td>
<td>89.84</td>
</tr>
<tr>
<td>PAPPA (&lt;0.45 MOM)</td>
<td>50</td>
<td>92.94</td>
<td>28</td>
<td>97.13</td>
<td>91.72</td>
</tr>
<tr>
<td>UtA PI (&gt;2.35)+PlGF (&lt;12 pg/ml)</td>
<td>92.85</td>
<td>87.6</td>
<td>28.88</td>
<td>99.54</td>
<td>87.59</td>
</tr>
<tr>
<td>UtAPI (&gt;2.35)+PlGF (&lt;12 pg/ml)+PAPPA-A (&lt;0.45MoM)</td>
<td>92.85</td>
<td>87.3</td>
<td>28.88</td>
<td>99.54</td>
<td>87.59</td>
</tr>
</tbody>
</table>

Table 4: Sensitivity, specificity, PPV, NPV and accuracy of UtA PI, PlGF, PAPP-A, UtAPI+PlGF and UtA PI+PlGF+PAPPA for prediction of IUGR. PPV: Positive Predictive Value; NPV: Negative Predictive Value; UtA: Uterine Artery; PI: Pulsatility Index; PlGF: Placental Growth Factor; PAPP-A: Pregnancy Associated Plasma Protein–A; IUGR: Intrauterine Growth Restriction.
angiogenic molecules, VEGF and PlGF and measurements of is considered an index of placental control. In placental development [9,10].

vascular resistance in the first trimester of pregnancy [8].

sFlt-1 in the models [17]. They also found the risk for PE and IUGR can be obtained with and without inclusion of sFlt-1 in the models [17]. They also found the risk for PE and IUGR was significantly increased for every log unit decrease in maternal serum PlGF levels in the first trimester.

The present study suggested that PI of UtAs and maternal serum PlGF in the first trimester may be ideal markers for PE and IUGR [11].

Chaiworapongsa et al. found that elevated sFlt-1 correlated with the severity and early onset of PE. However, Robinson et al. and Kim et al. observed no differences between mild and severe PE and early-onset and late-onset PE in terms of serum sFlt-1 but found the PE-related decrease in serum PlGF to be more pronounced in severe and early-onset PE [14-16].

A study of Thadhani et al. found that there was no statistical difference between maternal serum sFlt-1 levels in the first trimester in PE and IUGR and normal controls. In contrast to maternal serum sFlt-1, maternal serum PlGF levels did differ significantly compared with controls and thus subsequent risk for PE and IUGR can be obtained with and without inclusion of sFlt-1 in the models [17]. They also found the risk for PE and IUGR was significantly increased for every log unit decrease in maternal serum PlGF levels in the first trimester.

The ideal biomarker for PE and IUGR should be easily measured, simple, rapid, non-invasive, inexpensive, easy to perform, and should not expose the patient to discomfort or risk. The technology should be widely available and the results reproducible and reliable with a good sensitivity and specificity. Ideally it should provide an opportunity for intervention to prevent development of the disease or at least result in better maternal and/or fetal outcomes, should predict mild versus severe PE and IUGR, should delineate risk well early in pregnancy, best in the first trimester, and should serve as plausible mediator in its pathogenesis [18].

The present study suggested that PI of UtAs and maternal serum PlGF in the first trimester may be ideal markers for prediction of PE and IUGR as it had an accuracy of more than 87 and 89% respectively Tables 3 and 4. Elzen et al. (1995) examined 352 women at 12-13 weeks of pregnancy, best in the first trimester, and should serve as plausible mediator in its pathogenesis [18].

In 2005, Gomez et al. published a prospective trial in prediction of PE, IUGR. PI greater than the 95th percentile was used at the cut-off value they identify 24% of pregnancies complicated by PE and IUGR [20]. Crovetto et al. conducted a large prospective study including 9462 women who underwent first-trimester screening. The authors reported that 11-13 weeks UT A. Doppler was included in the beak model for prediction of PE was a high detection rate [21], Abd El moeyt et al. studied first trimester UtA PI for prediction of PE and IUGR, at a cut-off point of 2.37, sensitivity was 100% [22].
The study of Melchiore et al. showed that there were no significant differences in first-trimester mean UtA PI in prevalence of bilateral notching between women who had a normal pregnancy outcome and those who developed PE [23]. In 2009 Melchorre et al. carried out a prospective observational study and found that a mean UtA RI greater than 90th percentile in first trimester had a sensitivity of 25% for IUGR with specificity of 91.4% [24]. Martin et al. at 11-14 weeks gestations using the 95th percentile of mean PI as the screening threshold, the sensitivity and specificity for PE detection were 27% and 95.4% compared with 11.7% and 95.6% for IUGR [25]. Another study found the sensitivity and PPV of UtA PI, for prediction of PE, were low 27-81.3% and 3.1-11.3% respectively [26]. Dugoff et al. found, at 10-14 weeks gestation, UtA PI above the 95th percentile had a sensitivity of 16.6% and specificity of 95% in prediction of PE and IUGR and no significant association between notching (unilateral or bilateral) and development of these pregnancy complications [27].

The sensitivity and specificity of first trimester UtAPI in predicting of PE in eight studies was 25.4% and 93.3% respectively and for IUGR 15.4% and 93.3% respectively [28]. Consequent to these studies, it is plausible that the addition of maternal serum biomarkers of placental development may further improve prediction either by increasing sensitivity or by lowering the false positive rate.

PlGF is an angiogenic growth factor related to VEGF. Both are produced by the trophoblast. VEGF and PlGF are likely responsible for normal trophoblast proliferations, migration and invasion of the spiral arteries and their conversion to wide uteroplacental vessels. Consequently VEGF and PlGF are ideal biomarkers that may increase the sensitivity and positive predictive value of UtA PI for prediction of PE and IUGR [11,29].

Although some investigators have suggested that levels of PlGF have not altered among women subsequently developed PE and IUGR, others have reported just the opposite as PlGF levels decrease in cases to have PE and IUGR, from the first trimester of pregnancy. Levels of VEGF are undetectable in normal pregnancy outcome and those who developed PE [23]. In 2009 Melchiorre et al. carried out a prospective observational study and found that a mean UtA RI greater than 90th percentile in first trimester had a sensitivity of 25% for IUGR with specificity of 91.4% [24]. Martin et al. at 11-14 weeks gestations using the 95th percentile of mean PI as the screening threshold, the sensitivity and specificity for PE detection were 27% and 95.4% compared with 11.7% and 95.6% for IUGR [25]. Another study found the sensitivity and PPV of UtA PI, for prediction of PE, were low 27-81.3% and 3.1-11.3% respectively [26]. Dugoff et al. found, at 10-14 weeks gestation, UtA PI above the 95th percentile had a sensitivity of 16.6% and specificity of 95% in prediction of PE and IUGR and no significant association between notching (unilateral or bilateral) and development of these pregnancy complications [27].

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The ideal first trimester markers for prediction of PE and IUGR in low risk pregnant women may be a combination of UtA PI and maternal serum PlGF.

Acknowledgement
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References

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